PURCHASING GROUPS/POOLS

Summary of Relevant Literature[1]

Overview

Purchasing groups (or purchasing "pools," "cooperatives," "alliances," etc.) have been proposed as a way to increase access to health insurance for the uninsured, particularly by making insurance more accessible and affordable to small employers. Moreover, it was hoped that the presence of purchasing pools would stimulate healthy competition in the rest of the small-group market, resulting in expanded coverage and lower costs outside the pools.[2] Purchasing pools have been most frequently targeted to small-firm employers, although recent proposals include purchasing pools as the venue for individuals to purchase coverage using health insurance tax credits.[3]

Purchasing pools were designed to provide several advantages. First, purchasing pools were viewed as making health insurance more attractive because employers could offer employees a choice of plans, which would not otherwise be practical for small employers. Offering choices would presumably help small employers offer managed care plans without forcing all of their employees into a single HMO, thereby reducing health coverage costs.[4] Second, making insurance more affordable is viewed as critical to encouraging more small employers to offer coverage to employees,[5] and small employers are viewed by some as the most crucial factor in reducing the number of uninsured Americans.[6] Purchasing pools were seen as a means of lowering administrative costs, and giving small groups collective purchasing power to negotiate lower premium rates from insurance carriers and health plans.

The history and performance of purchasing pools within three states (California, Connecticut, and Florida) have been studied extensively.[7] These states have (or had) the largest small-group purchasing pools, and the pools all were based on common managed-care competition principles, including choice of plans, standardized benefits, and annual open enrollment periods. However the three states' pools differed greatly in administrative structure and governance, thus allowing a glimpse of factors contributing to their differential success.

The general evaluation of existing purchasing pools is equivocal.[8] Purchasing pools have clearly fallen short of expectations, although most policy experts agree that the problems that have plagued purchasing pools are fixable. The review of relevant literature is

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[1] This report was prepared for the Illinois Department of Insurance State Planning Grant by Jane L. Swanson, Southern Illinois University at Carbondale.
[2] Long & Marquis, 2001.
[3] Curtis, Neuschler, & Forland, 2000; Trude & Ginsburg, 2001.
[4] Wicks, Hall, & Meyer, 2000; Yegian et al., 2000.
[5] Jensen & Morrisey, 1999; Long & Marquis.
[6] Employee Benefit Research Institute, 2000.
[7] Long & Marquis, 2001. Additional states were studied by Wicks et al. (2000).
[8] Wicks *et al.*, 2000; Center for Studying Health System Change, 2001.

presented in three sections. The first section includes factors believed to contribute to the low enrollment in purchasing pools, including negative reaction by insurance agents and brokers, potential for adverse selection, reluctance of health plans and insurers to participate, and lack of promised price advantage and cost savings. Second, the intended consequences or effects of establishing purchasing pools are evaluated, such as increased choice of health plans, success in expanding coverage, and competitive effects on the health insurance market. In the third section, additional issues related to developing effective purchasing pools are discussed, such as ensuring sufficient enrollment, legislative and regulatory concerns, and intersection with other efforts to expand coverage.

Lessons Learned: Why Haven't Purchasing Pools Captured Greater Market Share?

Perhaps the greatest disappointment in the performance of purchasing pools is that they have achieved a very low share of the small-group market. For example, among employers who offered health insurance in three studied states, only 2-6% purchased through an available purchasing pool.[9] Achieving sufficient market share is the central issue to be addressed in evaluating past pools and designing future ones, serving as both a cause and an effect of some of the other factors reviewed below. For example, the relation between enrollment and health plan participation is the classic "chicken and egg" dilemma: Purchasing pools need substantial enrollment to have the bargaining clout necessary to negotiate discounts, yet without these discounts they cannot attract enrollment.[10]

Percentage of market share indicates purchasing pools' *relative* enrollment; however, despite the low percentage, in some areas the *absolute* enrollment in purchasing pools is quite large. For example, the California Health Insurance Plan had an enrollment of 150,000 in the year 2000. While this represents only 2-3% of the small-group market in the state, it is sufficiently large to be perceived as attractive by health plans.[11]

Role of Insurance Agents/Brokers

The designers of purchasing pools clearly underestimated the important role that agents and brokers play in the small-group market, and/or failed to provide sufficient commissions as incentive and reimbursement for the considerable time that agents invest. Brokers play an integral role in how small businesses obtain insurance: They help employers identify insurance products, complete paperwork, resolve problems, etc., and the vast majority of small employers report using an agent or broker to purchase health insurance.[12] Initially, purchasing pools in California and Florida were expected to save money by bypassing agents and brokers, yet the unintended effect was that brokers directed their clients to non-purchasing pool products. Agents and brokers also viewed

[9] Long & Marquis, 2001. Their study included the states of California, Connecticut, and Florida.
[10] Hall, Wicks, & Lawlor, 2001.
[11] Wicks *et al*, 2000.
[12] Hall, 2001; Long & Marquis, 2001.

purchasing pools as a threat to their business and therefore did not promote purchasing pool products to employers.[13]

Purchasing pool products also were not sufficiently marketed; for example, only 40% of employers offering health insurance in California were aware of the existence of state purchasing pools.[14] The lack of awareness clearly is related to agent participation, given the role that agents play in providing information to small businesses about their health insurance coverage options.[15] However, awareness doesn't necessarily translate into selection: 77% of employers who offered insurance in Connecticut were aware of the state's purchasing pools, yet the market share still did not exceed 10% among those who reported being aware of this option.[16]

In contrast to California and Florida, in which purchasing pools attempted to bypass insurance agents, Connecticut established an agent advisory board and solicited greater agent cooperation. However, Connecticut purchasing pools achieved only a slightly greater market share than did California or Florida.[17]

Adverse Selection

Purchasing pools often have a social mission – to make health insurance coverage available to a wider group of individuals and businesses, including those that are higher risk. However, pool organizers and administrators must be mindful of the balance between expanding coverage to the uninsured and avoiding adverse selection. If a purchasing pool is open to all employers while the rest of the insurance market is not, then the pool may become a "dumping ground" for high-risk employer groups, leading to spirals of adverse selection. On the other hand, allowing a pool to determine which employers may join will work against the goals of access and affordability, as a pool may select only those groups that have favorable risk profiles.[18]

If membership criteria are too lenient, the purchasing pool may attract higher risks. Some anecdotal evidence indicates that purchasing pools may be prone to high-risk individuals forming phony businesses in order to obtain health insurance. Small businesses may view insurance in a similar manner to people with individual coverage, obtaining and retaining insurance only when needed, which leads to higher claims and administrative costs. [19]

In addition, fears of adverse selection may keep health plans and insurers from initially contracting with purchasing pools.[20] However, differential risk selection does not appear

[13] Trude & Ginsburg, 2001; Yegian *et al*., 2000.
[14] Long & Marquis, 2001.
[15] Hall, 2000; Hall, 2001.
[16] Long & Marquis, 2001.
[17] Ibid; the market share was 6% in CT, compared to 2% in CA and 5% in FL, among employers who offered health insurance.
[18] Long & Marquis 1999.
[19] Trude & Ginsburg, 2001.
[20] Long & Marquis, 1999.

to be a factor in existing purchasing pools, relative to the non-pool market,[21] suggesting that the fear of adverse selection may not be borne out in reality.

One of the advantages (and demonstrated benefits) of purchasing pools is increased choice available to employers and employees. However, too many choices may exacerbate adverse selection within purchasing pools, as high-risk employees will choose plans with richer benefits. For example, a purchasing pool in Florida offered plans from 10 different insurance carriers, and two of the plans with richer benefits suffered adverse selection.[22]

Participation by Health Plans and Insurers

Another formidable problem is the attractiveness of purchasing pools to health plans and insurance carriers. Without health plan participation, purchasing pools do not have an attractive product to offer, and therefore cannot achieve the market penetration necessary to thrive.[23] Insufficient market penetration makes continued participation less attractive to insurers, which undermines the long-term viability of purchasing pools. Plans have withdrawn in several states, which contributed to the closing of some purchasing pools.[24]

A number of factors contribute to the reluctance of health plans to participate in purchasing pools. First, health plans would prefer to compete on variations in benefit design, provider networks, service levels, etc., rather than on price; yet purchasing pools entail standardized benefit packages and publicized premium rates.[25] Second, health plans are, understandably, not very motivated to encourage small groups to combine into larger ones with substantially more bargaining power to demand discounts and other concessions.[26] Third, insurers are concerned that purchasing cooperatives might become magnets for higher risk groups, as noted above.

Lack of Price Advantage and Cost Savings

Proponents of purchasing pools believed that they would result in significant reductions in premiums and in administrative costs. However, a major reason cited for the lackluster draw of purchasing pools is the lack of price advantage in terms of premiums. Although some pools initially offered lower premiums compared to non-pool plans, such price advantages did not persist, and recent evidence indicates that prices inside and outside purchasing pools are comparable. In some cases, premiums were higher within the pool than in other plans.[27]

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[21] Ibid; Long & Marquis, 2001. Differential risk itself was not measured directly, but rather was inferred by examining worker characteristics that are related to differential risk, such as sex, age, and earnings,
[22] Trude & Ginsburg, 2001.
[23] Curtis, Neuschler, & Forland, 2001.
[24] Long & Marquis, 2001; Wicks *et al*., 2000.
[25] Wicks *et al*., 2000.
[26] Curtis *et al.*, 2001; Hall *et al*., 2001.
[27] Long & Marquis, 1999; Long & Marquis, 2001; Wicks *et al*., 2000; Yegian *et al*., 2000.

Moreover, the potential of lower administrative costs was not realized,[28] primarily because purchasing pools have not become large enough to gain the advantage of economies of scale, and because they have duplicated rather than substituted administrative services (overlap with health plans and with agents and brokers). Administrative costs include marketing, enrollment processing, premium collection, all of which will always be higher for individuals and small business than for large companies.[29] On the other hand, some reductions in administrative costs are likely to occur when the purchasing pools reach sufficient size.

Consequences of Purchasing Pools

Increased Choice of Health Plans

Increasing the variety of health plans available to employees is an area in which purchasing pools have met their objectives. Participation in a purchasing pool increased the likelihood of employees being offered of a choice of plans, and the choices typically provided access to different types of plans, and particularly increased employees' opportunities to enroll in an HMO.[30] Employees, in turn, appeared to take advantage of greater choice by enrolling in a diversity of plans.[31]

Increased choice of health plans is a unique feature of purchasing pools, and is important in attracting small employers to the pools. Reports from insurance agents suggest that this feature is particularly attractive in very small firms where the employer has a close relationship with his or her employees, and cares about employees' reaction to decisions about health insurance coverage. Further, increased choice does not imply greater financial commitment from employers; they can base their premium contributions on the least expensive plan, and employees can choose more costly plans if they desire. [32]

Pool participants also received more information than non-participants from their employers to aid them in choosing a health plan. Purchasing pools may also make comparative shopping easier for employees because they typically include standardized benefit packages and published premium rates.[33]

Success in Expanding Coverage

Purchasing pools were expected to be appealing to small employers, for whom pools would provide decreased cost, increased access, and increased choice. Pooled purchasing arrangements (when broadly defined to include a number of pooled arrangements) are more prevalent among small businesses than large businesses, although such arrangements do not necessarily seem to attract small businesses that otherwise would not

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[28] Long & Marquis, 2001; Trude & Ginsburg, 2001; and Wicks *et al*., 2000.
[29] Trude & Ginsburg, 2001.
[30] Wicks *et al*., 2000. Purchasing pools generally have not been able to maintain a PPO option for participants, apparently due to health plans' fear of adverse selection.
[31] Long & Marquis, 1999; Long & Marquis, 2001.
[32] Wicks *et al*., 2000.
[33] Ibid.

offer health insurance to their employees.[34] Factors hypothesized to contribute to the lack of expanded coverage include the pools' inability to offer health insurance at lower prices and lack of cooperation from agents and brokers, as discussed earlier.[35]

Another way of measuring purchasing pools' success in expanding health insurance coverage is to determine whether they have reduced the number of uninsured workers (versus whether they have attained sufficient market share). There is little evidence that purchasing pools have had such an impact; they typically enroll about the same proportion of previously uninsured groups as the rest of the small-group market. Some analysts believe that expectations about the ability of purchasing pools to substantially reduce the number of uninsured were unrealistic; pools cannot reduce the cost of coverage sufficiently to increase coverage substantially.[36]

Competitive Effects on Health Insurance Markets

Some analysts hypothesized that the existence of purchasing pools would influence the broader small-group health insurance market by stimulating competition for enrollees, thus reducing premiums and expanding coverage. There is little hard evidence that such broader effect has been demonstrated, at least not in the three states studied thus far and in the measures used to operationalize such spillover effects. Further, because purchasing pools did not achieve significant market penetration, they simply could not exert enough competitive pressure on outside markets to achieve the anticipated spillover effects on premium costs.[37]

Anecdotally, pools have been credited with inducing some insurers to offer multiple benefit designs to their nonparticipating small-group clients, thereby increasing choice outside of the purchasing pools.[38]

Additional Issues to Consider

Ensuring Sufficient Enrollment

As noted earlier, achieving sufficient size and market share is crucial to the long-term viability of purchasing pools. The initial growth of some purchasing pools was not sustained over time, and pools simply did not achieve projected market penetration.[39] Analysts suggest that it is perhaps premature to judge purchasing pools' ability to attain a desired level of enrollment. Developing the market for purchasing pools is a challenging task, in part because pools essentially take business away from the direct sales that health plans would make to individuals or small firms. Further, purchasing pools must be

[34] Ibid. However, purchasing pools may cover a large proportion of very small "micro" groups (consisting of five or fewer employees) that may otherwise be uninsured because they are unattractive to insurers.
[35] Long & Marquis, 2001; Wicks *et al*., 2000.
[36] Curtis *et al*., 2001; Wicks *et al*., 2000. An analysis by Pauly and Herring (reported in Wicks *et al.*, 2000) suggests that subsidies would need to equal 1/3 to 1/2 of the premium in order to substantially reduce the number of uninsured.
[37] Long & Marquis, 2001; Wicks *et al*., 2000.
[38] Ibid.
[39] Ibid.

adequately marketed to the agents and brokers who are in the position of recommending pools to their small-business clients.[40]

Legislative/Regulatory Concerns

There are several different types of pooled purchasing arrangements, including new forms that have been proposed in each of the past three sessions of the U.S. Congress. Existing types include purchasing alliances, business coalitions, health insurance purchasing coalitions (HIPC), multiple employer welfare arrangements (MEWAs), trade and other associations. The newly proposed forms include HealthMarts and association health plans (AHPs).[41] The administrative and governance structures underlying these various types of pool purchasing arrangements vary considerably, with corresponding implications for employers and employees.

The overriding purpose of these proposals is to enable the small-group health insurance market to function more like the large-group market. However, these proposals, whether at the federal or state level, are not without controversy. The more recent proposals attempt to redress the discrepancy between larger and smaller purchasers by authorizing new forms of pooled purchasing for small groups and individuals, altering ERISA rules to preempt mandated-benefits laws within states, allowing association plans to offer self-insured coverage, and allowing rates to vary based on claims experience of each association pool.[42]

For example, association health plans (AHPs) would allow businesses with up to 100 employees to band together to purchase health insurance. AHPs would be exempt from state regulations, similar to self-insured plans of large employers, allowing them to operate across state lines and freeing them from state coverage mandates. According to small-business organizations, AHPs would lower their health care costs and increase their coverage options; the National Federation of Independent Business estimates that AHPs would result in 30% savings in administrative costs and 13% savings in premium costs.[43] The savings are presumed to result from increased purchasing power and economies of scale, avoiding mandated benefits, avoiding other unnecessary state regulations, and risk segmentation.[44] As noted earlier, however, the projected savings in administrative costs have not been realized in existing purchasing pools. Critics of the newly proposed purchasing arrangements such as AHPs question whether the 30% cost savings estimates are realistic.[45]

The incremental cost of state-mandated benefits has been cited as substantially increasing the level of health insurance premiums. One source estimates that mandated coverage increases premiums by 9% for substance abuse coverage, 15% for dental services, and

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[40] Wicks *et al*., 2000.
[41] Hall *et al*., 2001.
[42] Ibid.
[43] Kaiser Daily Health Policy Report, 2001, March 1
[44] Hall *et al*., 2001.
[45] Ibid.

13% for psychiatric hospital care.[46] However, exempting an insurer from state-mandated benefits may not lower the cost of health insurance for the consumer, because employers may not choose pared-down coverage, preferring instead to offer health benefits competitive to those offered by large employers.[47]

Moreover, consumer groups are concerned about the ramifications of exempting AHPs from state regulations. These concerns have been countered by adding provisions that set minimum solvency standards, grant states an oversight role, and require plans to pay state taxes to fund small group risk pools.[48]

Existing (or previous) purchasing pools in some states have been hampered by state legislation and mandates, related to risk selection, selective contracting, and competitive pricing. Some states required purchasing pools to be more lenient in accepting higher-risk groups than were health plans outside of the pools. Many purchasing pools were prohibited from negotiating prices with health plans, or were prevented by law from offering insurance at lower rates.[49]

Selective contracting is a necessary condition to offering health plans at lower prices, and yet purchasing pools in Florida were prohibited by state law from doing so; in other words, there were structural barriers preventing the pools from accomplishing one of their prime goals. Further, a factor cited as preventing purchasing pools from contributing to expanded coverage is that they did not offer a comparable product at a lower price. In two of the three states studied, the pools were prohibited by state law from doing so.[50]

Intersection of Purchasing Pools with Other Efforts to Expand Coverage

The future viability of purchasing pools will be influenced by the status of other efforts to expand health insurance coverage, particularly proposals that incorporate purchasing pools with other efforts. Most notable is explicit links between purchasing pools and either public subsides or tax credits.[51] For example, many states are considering expansion of SCHIP (KidCare in Illinois) to cover children at higher income levels and to cover parents. States could use purchasing pools to manage the flow of these increased subsidy dollars on behalf of workers in small firms, thus making employer-based health insurance coverage more available. Pools have the administrative capability to combine public funds (such as through SCHIP or Medicaid) with employer contributions, and send the combined funds to workers' chosen health plans. Workers in small firms would have the convenience of enrolling at the workplace, various family members could get their

[46] National Center for Policy Analysis, 1994.
[47] Hall *et al*., 2001.
[48] Kaiser Daily Health Policy Report, 2001, May 11.
[49] Long & Marquis, 2001; Wicks *et al*., 2000.
[50] Ibid.
[51] For more information on tax credits, see the reports on the State Planning Grant website (www.ins.state.il.us/spg).

health care coverage from the same plan, and pools would provide a stable source of coverage regardless of subsidy status or source of payment. [52]

Likewise, linking purchasing pools to tax credit proposals also will influence the future of purchasing pools. Health plans would be more likely to participate in response to the potential new enrollment represented by people with public subsidies. Large employer groups are attractive to health plans for the simple reason that workers receive large "subsidies" (employer contributions) that they cannot use to buy insurance elsewhere. Similarly, some proposals for individual health insurance tax credits require that the credits be used only for participation in purchasing pools, thereby minimizing the risk of adverse selection and providing a "captive audience" for health plans. If the tax credit were sufficiently large and could only be used to purchase health insurance through a purchasing pool, then participating in small-business pools would be the only way that health plans could access a substantial, largely healthy, new population. Plans thus should be motivated to contract with the purchasing pools.[53]

This option is designed to solve problems with both purchasing pools and with tax credits. Namely, purchasing pools need sufficient volume to be successful, and the proposed tax credits could be used only to purchase health coverage through state-sanctioned purchasing pools. Tax credits, on the other hand, suffer from the problems inherent in the individual insurance market; primarily, that individuals who are chronically ill or with a previous illness may not be able to obtain or afford health insurance as purchased in the individual market.

Summary

Despite the aforementioned problems, purchasing pools have produced demonstrable benefits to participants, and continue to hold promise as an avenue for increasing the number of small businesses that offer health insurance to their employees.[54]. Most states that introduced purchasing pools did so in the context of the debate over national health care reform, and undoubtedly expected that subsidies or mandates would be a component of such reform. In other words, states did not expect purchasing pools alone to solve the problem of the uninsured. Purchasing pools were viewed as a part of a larger, integrated health care reform package, to include health coverage mandates and federal subsidies.[55]

[52] Curtis *et al*., 2001.
[53] Curtis *et al*., 2001; Trude & Ginsburg, 2001.
[54] Long & Marquis, 2001.
[55] Long & Marquis, 2001; Wicks *et al*., 2000.

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